ACRL Allen County Right to Life

July 1, 2019

Angela Becker
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Ms. Becker,

Pursuant to the provisions of governing law, including but not limited to, I.C. §§ 5-14-3-1 and 3, I am requesting copies of the abortion facility license applications and supporting documentation for new abortion facilities from June 7, 2019 through July 1, 2019. I am also requesting copies of the abortion facility license renewal applications and supporting documentation for all abortion facilities operating the state. Licenses for existing abortion facilities expire June 30, 2019 according to my records.

Please send to the address below or e-mail to cathie.humbarger@ichooselife.org.

Please let me know of any cost related to this request and I will remit payment immediately.

Mail to:
Cathie Humbarger, VP
Indiana Right to Life
2126 Inwood Drive
Fort Wayne, IN 46815

Sincerely,

Cathie Humbarger

Executive Director
Allen County Right to Life

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

June 3, 2019

Facility 011133

LADONNA PRINCE, MANAGER
CLINIC FOR WOMEN
3607 W 16TH ST STE 2B
INDIANAPOLIS, IN 46222

Dear LADONNA PRINCE, MANAGER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN
Nurse Surveyor Supervisor
Program Director Hospitals/ASCs
317/232-3095

Enclosure (1)

Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Counseling of Indiana Inc. d/b/a
CLINIC FOR WOMEN
3607 W 16TH ST STE 2B
INDIANAPOLIS, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011133-1 is effective July 1, 2019 and expires June 30, 2020.

SEAL OF THE STATE OF INDIANA 1816

Randall Snyder

RANDALL SNYDER PT, MBA
DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH
MAIL MONEY RECEIPT

RECEIPT NO. 1964507

DATE 30-MAY-19

DIVISION ACUTE CARE (AC)

FROM CLINIC FOR WOMEN

STREET 3607 W 16TH ST

CITY INDPLS STATE IN 46222

BIRTHING CENTERS (Fund:17610, Program: 30000, Account: 423060, Department: 195129)	1,000.00

AMOUNT	$	1,000.00	CASH
CHECKS AND MONEY ORDERS	9011323982:	$1,000.00	

REFUND

MAIL CLERK
Wade, Amber

REMARKS

MAIL MR/FIN 1

State FORM 1086 (R7/12-04)

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

RECEIPT NO. 1964507

DATE 30-MAY-19

DIVISION ACUTE CARE (AC)

FROM CLINIC FOR WOMEN

STREET 3607 W 16TH ST

CITY INDPLS STATE IN 46222

BIRTHING CENTERS (Fund:17610, Program: 30000, Account: 423060, Department: 195129)	1,000.00

AMOUNT $	1,000.00	CASH

CHECKS AND MONEY ORDERS 9011323982: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS

State FORM 1086 (R7/12-04) MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

RECEIVED

MAY 31 2019

Indiana State Department of Health
Acute Care Division

RECEIVED

MAY 20 2019

Indiana State Department of Health
Acute Care Division

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-19)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ Date Approved *(mm/dd/yyyy)*_____ Date Rejected *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☒ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic: Clinic For Women

Street Address *(number and street)*: 3107 West 16th Street | P.O. Box:

City: Indianapolis | County: Marion | ZIP Code +4: 46222

Telephone Number: (317) 955-2641 | Fax Number: (317) 955-2687

Abortion Clinic e-mail address: cfw@clinic4women.net

Internet Web Address: www.clinic4women.net

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*: | P.O. Box:

City: | County: | ZIP Code +4:

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state: Counseling of Indiana

Street Address *(number and street)*: 3107 West 16th Street | P.O. Box:

City: Indianapolis | State: IN | ZIP Code+4: 46222

Telephone Number: (317) 955-2641 | Fax Number: (317) 955-2687 | EIN Number: 351391714 | Fiscal Year End Date *(mm/dd)*: 12-31

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: ☒ Laborstory: CLIA Certificate Number 15D0894576 ☐ Radiology ☒ Counseling ☐ Family Planning ☒ Pharmacy ☐ Other *(List)*: _____

2. Abortion Services: ☐ Drug Induced Only ☐ Surgical Only ☒ Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: 4 Registered Nurses: 1 Licensed Practical Nurses: 3 Licensed Social Workers: ☐

Other *(List title and number, do not use acronyms)*: 1 Receptionist 3 Surgical Assistants 3 Medical Assistants 2 Lab techs 2 PT. Educators 1 Specimen Tech 2 Nurse Practionis

E. Number of Procedure Rooms Utilizing:

Minimal Sedation 2 Moderate Sedation ☐

F. Type of Entity:

For Profit	Non-Profit	Government
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☒ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☐ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ Federal
		☐ Other *(specify)* _____

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
✓	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

G. Officers *(If the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO	LaDonna Prince	
Vice-President / Vice-Chairperson / COO	Sally Boone	
Treasurer / CFO	Alisha Dunn	
Secretary	Rita Jones	

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid then the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number
LaDonna Prince	3607 W. 16th St. Indpls, IN 46222	351317164
Dennis Mickle	3607 W. 16th St. Indpls, IN 46222	351317164

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ YES ☒ NO

Has any principal or clinic staff member been convicted of a felony? ☐ YES ☒ NO

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ YES ☒ NO

For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	MD
Printed Name and Title:	Dr. Raymond Robinson
Date of Signature *(mm/dd/yyyy)*:	5/17/19
Signature of the Clinic Administrator:	LaDonna Prince
Printed Name and Title:	LaDonna Prince, Director
Date of Signature *(mm/dd/yyyy)*:	05.20.2019

See the following page for instructions regarding licensure fees and submission of this application.

Clinic for Women

3607 W 16th St, Ste B2
Indianapolis, IN 46222-2556
P: (317) 955-2641 / F: (317) 955-2687
clinicforwomen.net / info@clinicforwomen.net

Physicians of Clinic For Women
3607 West 16th Street Ste B2
Indianapolis, IN 46222

RE: Backup Agreement

Dear

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in and in . I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact me by calling my office at . In addition, I will provide you with my cell phone and pager numbers. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

September 11, 2017

State of Indiana

Demographic Information

Name:

Address Information

City/State/Zip:

County:

License Information

Lic #: Profession: Medical Licensing Board Type: Physician Secondary:

Status: Active Issued: Expiration:

Method: Application

Discipline Information

Related Licenses

Lic #: Name:

License Type: Physician License Status: Active Relationship: Same Licensee

Specialty Information

Specialty: Obstetrics & Gynecology (OBG)

Documents

No Public Documents Available

June 11, 2018

Physicians of Clinic for Women
3607 West 16th Street, Suite B2
Indianapolis, Indiana 46222

RE: Backup Agreement

Dear

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have staff privileges in at in and in . I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact the staff by calling . Please provide the patient's name, reason for referral, current medical condition, and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

Sincerely,

June 20, 2017

Dear

It is my pleasure to inform you that the has approved your reappointment at in the . You have been reappointed to the Active category.

Your approved clinical privileges are effective . Your reappointment date is

Please log on to to carefully review your approved privileges for any modifications to the original submission. The instructions are attached. If you need a copy of your clinical privileges, please contact or

Medical Staff members (physicians and dentists) in the Active category: if you are not currently board certified, please review of the

Sincerely,

Attachment

Physicians of Clinic For Women
3607 West 16th Street Ste B2
Indianapolis, IN 46222

RE: Backup Agreement

Dear

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in at and in . I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact me by calling my office at . In addition, I will provide you with my cell phone and pager numbers. Please provide the patient's name, reason, for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

May 14, 2019

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited by . Our are accredited by the . We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:
Staff Appointment Date:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

June 25, 2019

Facility 011117

MEAGAN COOK
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
200 S. MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear MEAGAN COOK:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN
Nurse Surveyor Supervisor
Program Director Hospitals/ASCs
317/232-3095

Enclosure (1)

Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Planned Parenthood Of Indiana and Kentucky INC d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
421 S COLLEGE AVE
BLOOMINGTON, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011117-1 is effective July 1, 2019 and expires June 30, 2020.

Randall Snyder

RANDALL SNYDER PT, MBA
DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

RECEIPT NO. 1965443

DATE 07-JUN-19

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

AMOUNT	$	1,000.00	CASH

CHECKS AND MONEY ORDERS 69343: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

INDIANA STATE DEPARTMENT OF HEALTH
MAIL MONEY RECEIPT

DATE 07-JUN-19

RECEIPT NO. 1965443

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

AMOUNT	$	1,000.00	CASH

CHECKS AND MONEY ORDERS 69343: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS

State FORM 1086 (R7/12-04) MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-19)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ Date Approved *(mm/dd/yyyy)*_____ Date Rejected *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic: Planned Parenthood of Indiana and kentucky - Bloomington

Street Address *(number and street)*: 421 S. College Avenue | P.O. Box:

City: Bloomington | County: Monroe | ZIP Code +4: 47403

Telephone Number: (812) 336-0219 | Fax Number: (812) 336-2401

Abortion Clinic e-mail address: laura.miller@ppink.org

Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*: 200 S. Meridian St., Ste. 400 | P.O. Box:

City: Indianapolis | County: Marion | ZIP Code +4: 46225

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state: Planned Parenthood, INC

Street Address *(number and street)*: 200 S. Meridian St., Ste. 400 | P.O. Box:

City: Indianapolis | State: IN | ZIP Code+4: 46225

Telephone Number: (317) 637-4343 | Fax Number: (317) 637-4344 | EIN Number: 35-0874278 | Fiscal Year End Date *(mm/dd)*: 06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology [1] Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Abortion Services: ☐ Drug Induced Only ☐ Surgical Only [X] Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: [4] Registered Nurses: [2] Licensed Practical Nurses: [0] Licensed Social Workers: [0]

Other *(List title and number, do not use acronyms)*: Nurse Practitioner - 1, Assistants - 2, Admin -1

E. Number of Procedure Rooms Utilizing:

Minimal Sedation [2] Moderate Sedation [2]

F. Type of Entity:

For Profit

- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* _____

Non-Profit

- ☐ Church Related
- ☐ Individual
- ☐ Partnership
- ☑ Corporation
- ☐ Limited Liability Company
- ☐ Other *(specify)* _____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

G. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO	Donna Kerr	200 S Meridian St. Ste. 400 Indianapolis IN 46225
Vice-President / Vice-Chairperson / COO	Kristen Roby Dimlow	200 S Meridian St. Ste. 400 Indianapolis IN 46225
Treasurer / CFO	Terri Pickens Manweil	200 S Meridian St. Ste. 400 Indianapolis IN 46225
Secretary	Tuan Ngo	200 S Meridian St. Ste. 400 Indianapolis IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ YES ☑ NO

Has any principal or clinic staff member been convicted of a felony? ☐ YES ☑ NO

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ YES ☑ NO

For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	6/21/19
Signature of the Clinic Administrator:	Meagan Cook
Printed Name and Title:	Meagan Cook, Health Center Manager
Date of Signature *(mm/dd/yyyy)*:	06-20-2019

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
✔	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

RECEIVED

JUN 11 2019

Indiana State Department of Health
Acute Care Division

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ Date Approved *(mm/dd/yyyy)*_____ Date Rejected *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Planned Parenthood of Indiana and Kentucky - Bloomington

Street Address *(number and street)*	P.O. Box
421 S. College	

City	County	ZIP Code +4
Bloomington	Monroe	47403

Telephone Number	Fax Number
(812) 336-0219	(812) 336-2401

Abortion Clinic e-mail address: laura.miller@ppink.org

Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*	P.O. Box
200 S. Meridian Street, Suite 400	

City	County	ZIP Code +4
Indianapolis	Marion	46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state
Planned Parenthood of Indiana and Kentucky, INC.

Street Address *(number and street)*	P.O. Box
200 S. Meridian Suite 400	

City	State	ZIP Code+4
Indianapolis	Indiana	46225

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(317) 637-4343	(317) 637-4344	35-0874276	06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: [X] Laboratory: CLIA Certificate Number 15D0360690 [ ] Radiology [X] Counseling

[X] Family Planning [ ] Pharmacy [ ] Other *(List)*: _____

2. Surgical Services: [ ] Gynecology [ ] Other *(List)*: _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: [4] Registered Nurses: [2] Licensed Practical Nurses: [0]

Licensed Social Workers: [0] Other *(List title and number)*: Nurse Practioner-1
Assistants-2, Admin-1

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic [2] Moderate/Conscious Sedation [2]

F. Type of Entity:

For Profit	Non-Profit	Government
[ ] Individual	[ ] Church Related	[ ] State
[ ] Partnership	[ ] Individual	[ ] County
[ ] Corporation	[ ] Partnership	[ ] City
[ ] Limited Liability Company	[ ] Corporation	[ ] City/County
[ ] Sole Proprietorship	[ ] Limited Liability Company	[ ] Hospital District
[ ] Other *(specify)* _____	[ ] Other *(specify)* _____	[ ] Federal
		[ ] Other *(specify)* _____

G. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Donna Kerr	200 South Meridian, Suite 400 Indianapolis, IN 46225
Vice-President/Vice-Chairperson/COO	Kristen Roby Dimlow	200 South Meridian, Suite 400 Indianapolis, IN 46225
Treasurer/CFO	Terri Pickens Manwell	200 South Meridian, Suite 400 Indianapolis, IN 46225
Secretary	Tuan Ngo	200 South Meridian, Suite 400 Indianapolis, IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	5/15/2019
Signature of the Clinic Administrator:	Meagan Cook - HCM
Printed Name and Title:	Meagan Cook, Health Center Manager
Date of Signature *(mm/dd/yyyy)*:	5/15/2019

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
X	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236

Planned Parenthood®
Care. No matter what.

200 South Meridian Street Suite 400, Indianapds, IN 46225
Mailing Address: P.O. Box 397, Indianapolis IN 46206-0397
p:317.637.4343 · f:317.637.4344
www.ppinlorg

Planned Parenthood of Indiana and Kentucky

February 25, 2019

Planned Parenthood of Indiana and Kentueky
421 S College Ave
Bloomington, IN 47403

Re: Baekup Agreement for Monroe County

Drs.

This letter confirms our agreement that I will provide emergency back-up serviees for your abortion patients in the event of a eomplication, emergeney, or other medical need that requires hospitalization.

I have admitting privileges at i in , Indiana. As needed outside of usual eare practices, I will arrange for patient admission and carc according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and aceepted medical standard of eare, any patient needing immediate care should be evaluated at the closest emergency carc eenter.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medieal eondition and means of transport. *A* copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notiee if I need to modify or cancel this agrcement for any rea son.

Sincerelv.

August 23, 2017

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to , which includes and & , have been approved by the Board of Directors for to as a member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

November 07, 2018

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If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

June 27, 2018

RE: Membership and Clinical Privileges

Dear .

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to , which includes , and & , have been approved by the Board of Directors for to as a member of the Medical Staff.

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If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited by . Our are accredited by the . We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:
Staff Appointment Date:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

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Staff Appointment Date:
Staff Status:
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June 24, 2019

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The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:
Staff Appointment Date:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

June 25, 2019

Facility 011118

TAJUANA BYRD
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
200 S; MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear TAJUANA BYRD:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN
Nurse Surveyor Supervisor
Program Director Hospitals/ASCs
317/232-3095

Enclosure (1)

Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Planned Parenthhod Of Indiana and Kentucky d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
8590 GEORGETOWN RD
INDIANAPOLIS, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011118-1 is effective July 1, 2019 and expires June 30, 2020.

SEAL OF THE STATE OF INDIANA 1816

Randall Snyder

RANDALL SNYDER PT, MBA
DIRECTOR, ACUTE CARE DIVISION

State Form 4418-10 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

RECEIPT NO. 1965424

DATE 06-JUN-19

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

AMOUNT $ 1,000.00	CASH

CHECKS AND MONEY ORDERS 69341: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS INDPLS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

DATE 06-JUN-19

RECEIPT NO. 1965424

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

RECEIVED

JUN - 7 2019

Indiana State Department of Health
Acute Care Division

AMOUNT	$ 1,000.00	CASH

CHECKS AND MONEY ORDERS 69341: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS INDPLS

MAIL MR/FIN 1

State FORM 1086 (R7/12-04)

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R0 / 1-19)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 28)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ **Date Approved** *(mm/dd/yyyy)*_____ **Date Rejected** *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ **Change of Ownership** *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Planned Parenthood of Indiana and Kentucky - Indianapolis

Street Address *(number and street)*	P.O. Box
8590 Georgetown Road	

City	County	ZIP Code +4
Indianapolis	Marion	46268

Telephone Number	Fax Number	
(317) 872-3115	(317) 872-3118	Abortion Clinic e-mail address: annjeanettebottoms@ppink.org Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*	P.O. Box
200 S. Meridian Street, Suite 400	

City	County	ZIP Code +4
Indianapolis	Marion	46225

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state
Planned Parenthood of Indiana and Kentucky, INC.

Street Address *(number and street)*	P.O. Box
200 S. Meridian Street, Suite 400	

City	State	ZIP Code+4
Indianapolis	IN	46225

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(317) 637-4343	(317) 637-4344	35-0874276	06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number _____ ☐ Radiology ☐ Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Abortion Services: ☐ Drug Induced Only ☐ Surgical Only ☐ Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: [9] Registered Nurses: [2] Licensed Practical Nurses: [0] Licensed Social Workers: [0]

Other *(List title and number, do not use acronyms)*: _____

E. Number of Procedure Rooms Utilizing:

Minimal Sedation [2] Moderate Sedation [2]

F. Type of Entity:

For Profit	Non-Profit	Government
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☑ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ Federal
		☐ Other *(specify)* _____

G. Officers *(If the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO	Donna Kerr	200 S. Meridian St., Ste 400 Indianapolis, IN 46225
Vice-President / Vice-Chairperson / COO	Kristen Roby Dimlow	200 S. Meridian St., Ste 400 Indianapolis, IN 46225
Treasurer / CFO	Terri Pickens Manwell	200 S. Meridian St., Ste 400 Indianapolis, IN 46225
Secretary	Tuan Ngo	200 S. Meridian St., Ste 400 Indianapolis, IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid then the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ YES ☑ NO

Has any principal or clinic staff member been convicted of a felony? ☐ YES ☑ NO

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ YES ☑ NO

For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	6/21/19
Signature of the Clinic Administrator:	
Printed Name and Title:	AnnJeanette Bottoms, Area Service Director
Date of Signature *(mm/dd/yyyy)*:	6/21/19

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
✓	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ **Date Approved** *(mm/dd/yyyy)*_____ **Date Rejected** *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

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City	County	ZIP Code +4
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Telephone Number	Fax Number
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Abortion Clinic e-mail address: annjeanette.bottoms@ppink.org

Internet Web Address: www.ppink.org

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Indianapolis	Indiana	46225

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(317) 637-4343	(317) 637-4344	35-0874276	06/30

D. Services provided under this license:

Code items 1 and 2 as follows. 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Surgical Services: [1] Gynecology ☐ Other *(List)*: _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: [9] Registered Nurses: [2] Licensed Practical Nurses: [0]

Licensed Social Workers: [0] Other *(List title and number)*: _____

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic [2] Moderate/Conscious Sedation [2]

F. Type of Entity:

For Profit

- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* _____

Non-Profit

- ☐ Church Related
- ☐ Individual
- ☐ Partnership
- ☑ Corporation
- ☐ Limited Liability Company
- ☐ Other *(specify)* _____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

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Position	Name	Address/City/State/ZIP
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CERTIFICATION OF APPLICATION

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I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	5/15/2019
Signature of the Clinic Administrator:	
Printed Name and Title:	Tajuana Byrd, Health Center Manager
Date of Signature *(mm/dd/yyyy)*:	5/15/2019

See the following page for instructions regarding licensure fees and submission of this application.

January 15, 2019

Dear

It is my pleasure to inform you that the
has approved your reappointment at in the
. You have been reappointed to the Active category.

Your approved clinical privileges are effective . Your reappointment date is

Please log on to to carefully review your approved privileges for any modifications to the original submission. The instructions are attached. If you need a copy of your clinical privileges, please contact or .

Medical Staff members (physicians and dentists) in the Active category: If you are not currently board certified, please review of the .

Sincerely,

Attachment

June 27, 2018

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to , which includes , and , have been approved by the Board of Directors for to as a member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

Februery 16, 2018

Deer

I am heppy to notify you thet the Boerd of Directors, on the recommendation of the Medical Staff, has epproved your reappointment to the medical staff of
North. Your reeppointment period is effective from through .

A current copy of your delineation of privileges is enclosed.

The Board of Directors, Medical Steff and Administration eppreciate your continued service to the hospital. If you heve any questions pleese contect the Medical Steff Office at .

Sincerely,

November 07, 2018

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to , which includes , and & , have been approved by the Board of Directors for to as a member of the Medical Staff.

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If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

December 21, 2018

RE: Reappointment of privileges

Dear

Please allow this letter to confirm with you that the of the Board of Directors, has accepted a recommendation from the Medical Executive Committee to continue your membership and clinical privileges. Your reappointment period is from to .

As a member of the Medical Staff, you are expected to fulfill all requirements set forth in the Bylaws, Rules and Regulations and Policies and Procedures and to keep all records up to date. Bylaws are located on the Medical Staff Office at

Reappointment to the Medical Staff is contingent upon your maintaining the prescribed standards of the Bylaws and approved Medical Staff policies.

The Board of Directors, Medical Staff, and Administration appreciate your continued service to the hospital. Please contact the Medical Staff Office at if you have any questions.

Sincerely,

August 23, 2017

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to which includes and & , have been approved by the Board of Directors for to as a member of the Medical Staff.

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If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

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Facility:
Staff Appointment Date:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited by . Our are accredited by the . We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:
Staff Appointment Date:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

Print this Page

Medical Staff Membership or Affiliation

06/24/2019

Randall D Snyder
Division Director
Indiana State Department of Health

Re:

Is committed to the provision of quality care and is accredited by the . We engage in quality review activities for the purpose of concurrent and retrospective data collection, review and reporting. We continually monitor and evaluate the care our staff provides, including complication and mortality rates, number of admissions and procedures, peer review findings from drug usage evaluation, surgical case review, transfusion review, medical records review and departmental review, along with other indicators of the quality of care.

The practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Entity Name:
Staff Appointment Date:
Staff Status:
Department:
Category: Current
Credentialed From Date:
Credentialed To Date:

Entity Name:
Staff Appointment Date:
Staff Status: Active

Department:
Category: Current
Credentialed From Date:
Credentialed To Date:

Should you require additional information or if you have questions, please contact the Medical Staff Services Department at

Sincerely,

Print this Page

Medical Staff Membership or Affiliation

06/24/2019

Randall D Snyder
Division Director
Indiana State Department of Health

Re:

Is committed to the provision of quality care and is accredited by the . We engage in quality review activities for the purpose of concurrent and retrospective data collection, review and reporting. We continually monitor and evaluate the care our staff provides, including complication and mortality rates, number of admissions and procedures, peer review findings from drug usage evaluation, surgical case review, transfusion review, medical records review and departmental review, along with other indicators of the quality of care.

The practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Entity Name:
Staff Appointment Date:
Staff Status: Active
Department:
Category: Current
Credentialed From Date:
Credentialed To Date:

Entity Name:
Staff Appointment Date:
Staff Status:

Department:
Category: Current
Credentialed From Date:
Credentialed To Date:

Should you require additional information or if you have questions, please contact the Medical Staff Services Department at

Sincerely,

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

June 25, 2019

Facility 013765

KALILA WEINER
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC -
200 S. MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear KALILA WEINER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

Jennifer Hembree RN

JENNIFER HEMBREE RN
Nurse Surveyor Supervisor
Program Director Hospitals/ASCs
317/232-3095

Enclosure (1)

Indiana State Department of Health

Abortion Clinic License

This is to certify that:

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC - LAFAYETTE d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC -
964 MEZZANINE DR
LAFAYETTE, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-013765-1 is effective July 1, 2019 and expires June 30, 2020.

Randall Snyder

RANDALL SNYDER PT, MBA
DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

DATE 06-JUN-19

RECEIPT NO. 1965423

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	500.00

AMOUNT $ 500.00	CASH

CHECKS AND MONEY ORDERS 69342: $500.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS LAFAYETTE

State FORM 1086 (R7/12-04) MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

DATE 06-JUN-19

RECEIPT NO. 1965423

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	500.00

RECEIVED
JUN - 7 2019
Indiana State Department of Health
Acute Care Division

AMOUNT	$	500.00	CASH
CHECKS AND MONEY ORDERS	69342:	$500.00	

REFUND

MAIL CLERK
Wade, Amber

REMARKS LAFAYETTE

MAIL MR/FIN 1

State FORM 1086 (R7/12-04)

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-18)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ **Date Approved** *(mm/dd/yyyy)*_____ **Date Rejected** *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic: Plannad Parenthood of Indiana and Kentucky - Lafayette

Street Address *(number and street)*: 964 Mezzanine Driva | P.O. Box:

City: Lafayetta | County: Tippacanoe | ZIP Code +4: 47905

Telephone Number: (765) 286-3701 | Fax Number: (765) 446-8160

Abortion Clinic e-mail address: maritza.torres@pplnk.org

Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*: 200 S. Meridlan St., Ste. 400 | P.O. Box:

City: Indianapolis | County: Marion | ZIP Code +4: 46225

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state: Plannad Parenthood of Indiana and Kentucky, INC

Street Address *(number and street)*: 200 S. Maridian St., Ste. 400 | P.O. Box:

City: Indianapolis | State: IN | ZIP Code+4: 46225

Telephone Number: (317) 637-4343 | Fax Number: (317) 637-4344 | EIN Number: 35-0874276 | Fiscal Year End Date *(mm/dd)*: 06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Abortion Services: [X] Drug Induced Only ☐ Surgical Only ☐ Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: [3] Registered Nurses: [0] Licensed Practical Nurses: [0] Licensed Social Workers: [0]

Other *(List title and number, do not use acronyms)*: _____

E. Number of Procedure Rooms Utilizing:

Minimal Sedation [0] Moderate Sedation [0]

F. Type of Entity:

For Profit	Non-Profit	Government
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☑ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ Federal
		☐ Other *(specify)* _____

G. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO	Donna Kerr	200 S. Meridian St. Ste. 400 Indianapolis, IN 46225
Vice-President / Vice-Chairperson / COO	Kristen Roby Dimlow	200 S. Meridian St. Ste. 400 Indianapolis, IN 46225
Treasurer / CFO	Terri Pickens Manwell	200 S. Meridian St. Ste. 400 Indianapolis, IN 46225
Secretary	Tuan Ngo	200 S. Meridian St. Ste. 400 Indianapolis, IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ YES ☑ NO

Has any principal or clinic staff member been convicted of a felony? ☐ YES ☑ NO

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ YES ☑ NO

For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	6/21/19
Signature of the Clinic Administrator:	Kailla Weiner, HCM
Printed Name and Title:	Kailla Weiner, Health Center Manager
Date of Signature *(mm/dd/yyyy)*:	06/20/19

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
✔	Zero to 799	$500.00
	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*._____ Date Approved *(mm/dd/yyyy)*._____ Date Rejected *(mm/dd/yyyy)*._____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

D New Facility ☒ Renewal D Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))*
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Planned Parenthood of Indiana and Kentucky – Lafayette

Street Address *(number and street)*	P.O. Box
964 Mezzanine Drive	

City	County	ZIP Code +4
Lafayette	Tippecanoe	47905

Telephone Number	Fax Number	
(317)872-3115	(317)872-3118	Abortion Clinic e-mail address: martiza.torres@ppink.org
		Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*	P.O. Box
200 South Meridian, Suite 400	

City	County	ZIP Code +4
Indianapolis	Marion	46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, INC

Street Address *(number and street)*	P.O. Box
200 South Meridian Street, Suite 400	

City	State	ZIP Code+4
Indianapolis	Indiana	46225

Telephone Number	Fax Number		Fiscal Year End Date *(mm/dd)*
(317) 637-4344	(317) 637-4344	EIN Number 35-0874276	06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Surgical Services: [1] Gynecology ☐ Other *(List)*: _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: [3] Registered Nurses: [0] Licensed Practical Nurses: [0]

Licensed Social Workers: [0] Other *(List title and number)*: _____

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic [0] Moderate/Conscious Sedation [0]

F. Type of Entity:

For Profit

- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* _____

Non-Profit

- ☐ Church Related
- ☐ Individual
- ☐ Partnership
- ☑ Corporation
- ☐ Limited Liability Company
- ☐ Other *(specify)* _____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

G. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Donna Kerr	200 South Meridian, Suite 400 Indianapolis, IN 46225
Vice-President/Vice-Chairperson/COO	Kristen Roby Dimlow	200 South Meridian, Suite 400 Indianapolis, IN 46225
Treasurer/CFO	Terri Pickens Manwell	200 South Meridian, Suite 400 Indianapolis, IN 46225
Secretary	Tuan Ngo	200 South Meridian, Suite 400 Indianapolis, IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	5/15/2019
Signature of the Clinic Administrator:	Kalila Weiner
Printed Name and Title:	Kalila Weiner, Health Center Manager
Date of Signature *(mm/dd/yyyy)*:	5/15/2019

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
✓	Zero to 799	$500.00
	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236

Planned Parenthood®
Care. No matter what.

200 South Meridian Street, Suite 400, Indianapolis 46225
Mailing Address P.O. Box 397, Indianapolis 46206-0397
p: 317.637.4343 · f: 317.637.4344
www.ppink.org

Planned Parenthood of Indiana and Kentucky

May 22, 2019

Planned Parenthood of Indiana and Kentucky
964 Mezzanine Dr
Lafayette, IN 47905

Re: Baekup Agreement for Tippceanoe County

Drs.,

This letter eonfirms our agreement that I will provide emergency back-up serviees for your abortion patients in the event of a complication, emergeney, or other medieal need that requires hospitalization.

I have admitting privileges in at , Indiana. As needed outside of usual care praetiees, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate eare should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or eaneel this agreement for any reason.

Sincerely,

November 01, 2017

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited by . Our are accredited by the . We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:
Staff Appointment Date:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited by . Our are accredited by the . We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:
Staff Appointment Date: From:
Staff Status:
Department/Section:
Specialty:

If you need additional information, please contact me.

Sincerely,

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

June 25, 2019

Facility 011116

LOLITA KINSEY-BROWN
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
200 S. MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear LOLITA KINSEY-BROWN:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN
Nurse Surveyor Supervisor
Program Director Hospitals/ASCs
317/232-3095

Enclosure (1)

Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Planned Parenthood Of Indiana and Kentucky INC d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
8645 CONNECTICUT ST
MERRILLVILLE, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011116-1 is effective July 1, 2019 and expires June 30, 2020.

SEAL OF THE STATE OF INDIANA 1816

Randall Snyder

RANDALL SNYDER PT, MBA
DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

RECEIPT NO. 1965425

DATE 06-JUN-19

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

AMOUNT	$	1,000.00	CASH

CHECKS AND MONEY ORDERS 69340: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS MERRILLVILLE

State FORM 1086 (R7/12-04) MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

RECEIPT NO. 1965425

DATE 06-JUN-19

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS STATE IN 46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

RECEIVED
JUN - 7 2019
Indiana State Department of Health
Acute Care Division

AMOUNT	$	1,000.00	CASH
CHECKS AND MONEY ORDERS	69340:	$1,000.00	

REFUND

MAIL CLERK
Wade, Amber

REMARKS MERRILLVILLE

State FORM 1086 (R7/12-04) MAIL MR/FIN 1

SBH 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-19)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ Date Approved *(mm/dd/yyyy)*_____ Date Rejected *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Planned Parenthood of Indiana and Kentucky - Merrillville

Street Address *(number and street)*	P.O. Box
8645 Connecticut Street	

City	County	ZIP Code +4
Merrillville	Lake	46410

Telephone Number	Fax Number	
(219) 525-3001	(219) 791-0538	Abortion Clinic e-mail address: lolita.kinsey-brown@ppink.org Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*	P.O. Box
200 S. Meridian Street, Ste. 400	

City	County	ZIP Code +4
Indianapolis	Marion	46225

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state
Planned Parenthood of Indiana and Kentucky, INC

Street Address *(number and street)*	P.O. Box
200 S. Meridian Street, Ste. 400	

City	State	ZIP Code+4
Indianapolis	IN	46225

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(317) 637-4343	(317) 637-4344	35-0874276	06/30

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Abortion Services: ☐ Drug Induced Only ☐ Surgical Only [X] Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: [7] Registered Nurses: [2] Licensed Practical Nurses: [0] Licensed Social Workers: [0]

Other *(List title and number, do not use acronyms)*: _____

E. Number of Procedure Rooms Utilizing:

Minimal Sedation [2] Moderate Sedation [0]

F. Type of Entity:

For Profit	Non-Profit	Government
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☑ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)* _____	☐ Other *(specify)* _____	☐ Federal
		☐ Other *(specify)* _____

G. Officers *(If the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO	Donna Kerr	200 S Meridian St. Ste. 400 Indianapolis, IN 46225
Vice-President / Vice-Chairperson / COO	Kristen Roby Dimlow	200 S Meridian St. Ste. 400 Indianapolis, IN 46225
Treasurer / CFO	Terri Pickens Manwell	200 S Meridian St. Ste. 400 Indianapolis, IN 46225
Secretary	Tuan Ngo	200 S Meridian St. Ste. 400 Indianapolis, IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ YES ☑ NO

Has any principal or clinic staff member been convicted of a felony? ☐ YES ☑ NO

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ YES ☑ NO

For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	6/21/19
Signature of the Clinic Administrator:	Lolita Kinsey-Brown
Printed Name and Title:	Lolita Kinsey-Brown, Area Service Director
Date of Signature *(mm/dd/yyyy)*:	6/20/19

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures In the Clinic	Fee
	Zero to 799	$500.00
✓	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*,_____ Date Approved *(mm/dd/yyyy)*,_____ Date Rejected *(mm/dd/yyyy)*,_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

D New Facility [X] Renewal D Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))*
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Planned Parenthood of Indiana and Kentucky – Merrivile

Street Address *(number and street)*	P.O. Box
8645 Connecticut Street	

City	County	ZIP Code +4
Merriville	Lake	46410

Telephone Number	Fax Number	
(317)872-3115	(317)872-3118	Abortion Clinic e-mail address: Lolita.kinsey-brown@ppink.org.
		Internet Web Address: www.ppink.org

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*	P.O. Box
200 South Meridian, Suite 400	

City	County	ZIP Code +4
Indianapolis	Marion	46225

C. Licensee/Ownership Information

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, INC

Street Address *(number and street)*	P.O. Box
200 South Meridian Street, Suite 400	

City	State	ZIP Code+4
Indianapolis	Indiana	46225

Telephone Number	Fax Number		Fiscal Year End Date *(mm/dd)*
(317) 637-4344	(317) 637-4344	EIN Number 35-0874276	06/30

D. Services provided under this license:

Code items 1 and 2 as follows. 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: [1] Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

[1] Family Planning ☐ Pharmacy ☐ Other *(List)*: _____

2. Surgical Services: [1] Gynecology ☐ Other *(List)*: _____

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons

3. Staffing: Physicians: [7] Registered Nurses: [2] Licensed Practical Nurses: [0]

Licensed Social Workers: [0] Other *(List title and number)*: [illegible]

E. Number of Procedure Rooms Utilizing:

Local analgesia/anesthetic [2] Moderate/Conscious Sedation [0]

F. Type of Entity:

For Profit

- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Other *(specify)* _____

Non-Profit

- ☐ Church Related
- ☐ Individual
- ☐ Partnership
- ☑ Corporation
- ☐ Limited Liability Company
- ☐ Other *(specify)* _____

Government

- ☐ State
- ☐ County
- ☐ City
- ☐ City/County
- ☐ Hospital District
- ☐ Federal
- ☐ Other *(specify)* _____

G. Officers *(if the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Donna Kerr	200 South Meridian, Suite 400 Indianapolis, IN 46225
Vice-President/Vice-Chairperson/COO	Kristen Roby Dimlow	200 South Meridian, Suite 400 Indianapolis, IN 46225
Treasurer/CFO	Terri Pickens Manweil	200 South Meridian, Suite 400 Indianapolis, IN 46225
Secretary	Tuan Ngo	200 South Meridian, Suite 400 Indianapolis, IN 46225

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Deb Nucatola, Medical Director
Date of Signature *(mm/dd/yyyy)*:	5/15/2019
Signature of the Clinic Administrator:	Lolita Kinsey-Brown
Printed Name and Title:	Lolita Kinsey-Brown, Area Service Director
Date of Signature *(mm/dd/yyyy)*:	5/15/2019

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
X	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) *a copy (in writing) of that physician's admitting privileges.*

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. 0. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236

Planned Parenthood®
Care. No matter what.

200 South Meridian Street, Suite 400, Indianapolis, IN 46225
Mailing Address: P.O. Box 397, Indianapolis, IN 46206-0397
p: 317.637.4343 · f: 317.637.4344
www.pplnk.org

Planned Parenthood of Indiana and Kentucky

May 22, 2019

Planned Parenthood of Indiana and Kentucky
8645 Connecticut St
Merrillville, IN 46410

Re: Backup Agreement for Lake County

Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have admitting privileges in at in Indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely,

Electronic signature for

April 27, 2018

Dear

On behalf of the Board of Trustees, it is my pleasure to inform you that your reappointment to the Medical Staff has been approved. You have been granted membership on the Active staff with clinical privileges in beginning through .

Clinical privileges have been granted as specified on the enclosed Privileges form. Please review these carefully, as you have only been granted privileges to perform those procedures outlined on your Delineation of Privileges form.

As a member of the Medical Staff, you are required to abide by all hospital policies and the Code of Ethical Conduct. Your reappointment is subject to the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and all other Medical Staff Policies and Procedures that are in force during the term of your appointment.

Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office for assistance at .

We appreciate your continued support and value your contribution as a member of the Medical Staff.

Sincerely,

Enclosure: Clinical Privileges

Indiana State Department of Health
An Equal Opportunity Employer

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

Abortion Clinic Licensure
Physician Admitting Privileges Verification Report

Date: 06/24/2019

Clinic: Planned Parenthood Of Indiana And Kentucky Inc
8645 Connecticut St
Merrillville, IN 46410-6222

Reason for Verification: __x__ Licensure _____ Status Change

IC 16-34-2-4.5(a)(1) Admitting Privileges (without a written agreement with another physician)

Clinic Physician's Name:

Hospital:

Confirmed by:

(Name and Title of Hospital Representative)

Date Verified:

Verified by:

IC 16-34-2-4.5(a)(2) Admitting privileges under a written agreement with another physician

Name of Clinic Physician covered by the agreement:

Admitting Physician

Hospital:

Confirmed by:

(Name and Title of Hospital Representative)

Date Verified: June 24, 2019

Verified by: R. Snyder, Division Director Acute Care

Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

Indiana State
Department of Health
An Equal Opportunity Employer

June 7, 2019

Facility 011128

W. MARTIN HASKELL, M.D.
WOMEN'S MED GROUP PROFESSIONAL CORPORATION
PO BOX 43100
CINCINNATI, OH 45243

Dear W. MARTIN HASKELL, M.D.:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

Jennifer Hembree RN

JENNIFER HEMBREE RN
Nurse Surveyor Supervisor
Program Director Hospitals/ASCs
317/232-3095

Enclosure (1)

Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Women's Med Group Professional Corporation d/b/a
WOMEN'S MED GROUP PROFESSIONAL CORPORATION
1201 N ARLINGTON AVE
INDIANAPOLIS, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011128-1 is effective July 1, 2019 and expires June 30, 2020.

SEAL OF THE STATE OF INDIANA 1816

Randall Snyder

RANDALL SNYDER PT, MBA
DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

RECEIVED

Indiana State Department of Health
Acute Care Division

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

DATE 31-MAY-19

RECEIPT NO. 1964699

DIVISION ACUTE CARE (AC)

FROM THE WOMEN'S MED & CENTER

STREET PO BOX 43100

CITY CINCINNATI STATE OH - 45243

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

AMOUNT $ 1,000.00	CASH

CHECKS AND MONEY ORDERS 61092: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS

State FORM 1086 (R7/12-04) MAIL RR/FIN 1

SDR 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

RECEIVED

Indiana State Department of Health
Acute Care Division

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

DATE 31-MAY-19

RECEIPT NO. 1964699

DIVISION ACUTE CARE (AC)

FROM THE WOMEN'S MED & CENTER

STREET PO BOX 43100

CITY CINCINNATI STATE OH - 45243

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)	1,000.00

AMOUNT $ 1,000.00

CASH

CHECKS AND MONEY ORDERS 61092: $1,000.00

REFUND

MAIL CLERK
Wade, Amber

REMARKS

State FORM 1086 (R7/12-04) MAIL MR/FIN 1

SBR 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

DISTRIBUTION : White-Division, Canary-Division, Pink-Cashier

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-19)
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

RECEIVED

JUN 07 2019

Indiana State Department of Health
Acute Care Division

Division of Acute Care Use Only

Date Received *(mm/dd/yyyy)*_____ Date Approved *(mm/dd/yyyy)*_____ Date Rejected *(mm/dd/yyyy)*_____

Please Type or Print Legibly.

SECTION I - TYPE OF APPLICATION

Application *(Check appropriate item.)*

☐ New Facility ☑ Renewal ☐ Change of Ownership *(Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy))* _____
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

SECTION II - IDENTIFYING INFORMATION

A. Abortion Clinic Location

Name of Abortion Clinic
Women's Med Group Professional Corporation dba Women's Med Indianapolis

Street Address *(number and street)*	P.O. Box
1201 N Arlington Ave	

City	County	ZIP Code +4
Indianapolis	Marion	46219

Telephone Number	Fax Number	
(317) 353 9371	(317) 322 3358	Abortion Clinic e-mail address: martyh@fortemgt.com Internet Web Address: womensmed.com

B. Mailing Address *(if different from abortion clinic location)*

Street Address *(number and street)*	P.O. Box
	43100

City	County	ZIP Code +4
Cincinnati, OH	Hamilton	45243-0100

C. Licensee / Ownership Information

Licensee: The applicant entity as registered with the secretary of state
Women's Med Group Professional Corporation

Street Address *(number and street)*	P.O. Box
	43100

City	State	ZIP Code+4
Cincinnati	OH	45243-0100

Telephone Number	Fax Number	EIN Number	Fiscal Year End Date *(mm/dd)*
(513) 272 0002	(513) 272 0052	31-1148155	12/31

D. Services provided under this license:

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: [3] Laboratory: CLIA Certificate Number 15D353797 [1] Radiology [1] Counseling [1] Family Planning [1] Pharmacy [ ] Other *(List)*: _____

2. Abortion Services: [ ] Drug Induced Only [ ] Surgical Only [1] Both Drug Induced and Surgical

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing ; Physicians: [1] Registered Nurses: [0] Licensed Practical Nurses: [3] Licensed Social Workers: [0]

Other *(List title and number, do not use acronyms)*: Advanca Practice Nurses 3, Medical Assistants 5

E. Number of Procedure Rooms Utilizing:

Minimal Sedation [2] Moderate Sedation [0]

F. Type of Entity:

For Profit	Non-Profit	Government
[ ] Individual	[ ] Church Related	[ ] State
[ ] Partnership	[ ] Individual	[ ] County
[x] Corporation	[ ] Partnership	[ ] City
[ ] Limited Liability Company	[ ] Corporation	[ ] City/County
[ ] Sole Proprietorship	[ ] Limited Liability Company	[ ] Hospital District
[ ] Other *(specify)* _____	[ ] Other *(specify)* _____	[ ] Federal
		[ ] Other *(specify)* _____

G. Officers *(If the business entity is incorporated)*

Position	Name	Address/City/State/ZIP
President / Chairperson / CEO	Martin Haskell, MD	PO Box 43100, Cincinnati OH 45243
Vice-President / Vice-Chairperson / COO	Valerie Haskell	PO Box 43100, Cincinnati OH 45243
Treasurer / CFO	Martin Haskell, MD	PO Box 43100, Cincinnati OH 45243
Secretary	Valerie Haskell	PO Box 43100, Cincinnati OH 45243

H. Ownership and/or Change in Ownership:

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(Use additional sheet if necessary.)*

Name	Business Address/City/State/ZIP	EIN Number
Martin Haskell, MD	PO Box 43100, Cincinnati, OH 45243	

I. Declarations:

Has any applicant, or an owner or affiliate of the applicant, operated an abortion clinic that was closed as a direct result of patient health and safety concerns? ☐ YES ☑ NO

Has any principal or clinic staff member been convicted of a felony? ☐ YES ☑ NO

Has any principal or clinic staff member ever employed by a facility owned or operated by the applicant that closed as a result of administrative or legal action? ☐ YES ☑ NO

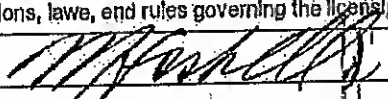
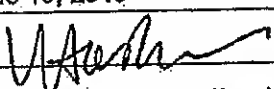
For any YES responses: attach copies of administrative and legal documentation, inspection reports, violations and remediation contracts.

CERTIFICATION OF APPLICATION

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statues, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Martin Haskell
Date of Signature *(mm/dd/yyyy)*:	June 19, 2019
Signature of the Clinic Administrator:	
Printed Name and Title:	Valerie Haskell, Vice-President
Date of Signature *(mm/dd/yyyy)*:	June 10, 2019

See the following page for instructions regarding licensure fees and submission of this application.

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	$500.00
✓	800 to 3,499	$1,000.00
	3,500 to 6,999	$2,000.00
	7,000 and above	$3,000.00

410 IAC 15-5-3

Enclose the following:

1. A completed Application for License to Operate an Abortion Clinic (this form).

2. Any supporting attachments.

3. For each physician performing procedures, either:

(A) A copy (in writing) of the physician's admitting privileges; or
(B) A copy of:
(1) his/her written agreement with another physician with admitting privileges; and
(2) a copy (in writing) of that physician's admitting privileges.

4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
ATTENTION: CASHIER'S OFFICE, 2-C
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204

May 22, 2019

RE: Backup Agreement in Marion County, Indiana

Dear Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have privileges in at in Indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per medical standard of care, any patient needing immediate care should be evaluated at the nearest emergency care center.

In the event my services are needed under this agreement, contact me by calling the shared phone numbers. I have provided you with my office and cell phone numbers. Please provide the patient's name, reason for referral, current medical condition, and means of transport. A copy of all available patient records should be sent with the patient if possible.

Attached is current proof of hospital privileges. I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely.

January 15, 2019

Dear

It is my pleasure to inform you that the has approved your reappointment at In the . You have been reappointed to the Active category.

Your approved clinical privileges are effective . Your reappointment date is

Please log on to . carefully review your approved privileges for any modifications to the original submission. The instructions are attached. If you need a copy of your clinical privileges, please contact or .

Medical Staff members (physicians and dentists) in the Active category: If you are not currently board certified, please review of the .

Sincerely,

Attachment

June 24, 2019

To Whom It May Concern:

This letter is to verify that , was granted temporary privileges on . He was appointed to the Medical Staff of on .

is an Active member of our department and has admitting privileges. He meets the necessary requirements to maintain membership and/or clinical privileges on the Medical Staff.

If you have any further questions, please contact me at .

Sincerely,

RECEIVED

JUN 07 2019

Indiana State Department of Health
Acute Care Division

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FORTE MANAGEMENT CORP
PO BOX 43100
CINCINNATI OH 45243-0100

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2 N MERIDIAN ST
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